

maintain existing outreach programs. The plan must—

(1) Address cancer prevention for cancers that are prevalent in the designated populations or cancers that are targeted by the qualifying hospital, interventions, and goals for decreasing the targeted cancer rates during the loan deferment program; and

(2) Address early diagnosis of cancers that are prevalent in the designated populations or cancers that are targeted by the qualifying hospital, interventions, and goals for improving early diagnosis rates for the targeted cancer(s) during the loan deferment period;

(3) Address cancer treatment for cancers that are prevalent in the designated populations or cancers that are targeted by the qualifying hospital, interventions, and goals for improving cancer treatment rates for the targeted cancer(s) during the loan deferment; and

(4) Identify the measures that will be used to determine the qualifying hospital's annual progress in meeting the initial goals specified in paragraphs (a)(1) through (a)(3) of this section.

(b) *Unique research resources.* The plan must specify how the qualifying hospital will establish or maintain existing unique research resources or an affiliation with an entity that has unique research resources.

**§ 505.17 Reporting requirements for meeting the conditions for loan forgiveness.**

(a) *Annual reporting requirements.* On an annual basis, beginning one year from the date that CMS notified the qualifying hospital of the loan award, the qualifying hospital must submit a report to CMS that updates the plan specified in § 505.15 by—

(1) Describing the qualifying hospital's progress in meeting its initial plan goals;

(2) Describing any changes to the qualifying hospital's initial plan goals; and

(3) Including at least one measure used to track the qualifying hospital's progress in meeting its plan goals.

(b) *Review of annual reports.* CMS will review each qualifying hospital's annual report to provide the hospital with feedback regarding its loan forgiveness status. If CMS determines that the annual report shows that the qualifying hospital has fulfilled the conditions, plan criteria, and reporting requirements for loan forgiveness specified in §§ 505.13, 505.15, and 505.17, CMS will notify the qualifying hospital in writing that the loan is forgiven.

(c) *Final annual reporting requirements.* A qualifying hospital must submit its final report to CMS at least 6 months before the end of the loan deferment period specified in § 505.7(b).

**§ 505.19 Approval or denial of loan forgiveness.**

(a) *Approval of loan forgiveness.* If CMS determines that a qualifying hospital has met the conditions, plan criteria, and reporting requirements for loan forgiveness specified in §§ 505.13, 505.15, and 505.17, CMS will send a written notification of approval for loan forgiveness to the qualifying hospital by the earlier of—

(1) 30 days from the date of receipt of the annual report that shows the qualifying hospital has satisfied the requirements for loan forgiveness; or

(2) 90 days before the end of the loan deferment period defined in § 505.7(b).

(b) *Denial of loan forgiveness.* If CMS determines that a qualifying hospital has not met the conditions, plan criteria, or reporting requirements for loan forgiveness specified in §§ 505.13, § 505.15, or § 505.17 of this part, CMS will send a written notification of denial of loan forgiveness to the qualifying hospital at least 30 days before the end of the loan deferment period defined in § 505.7(b).



# CHAPTER V—OFFICE OF INSPECTOR GENERAL-HEALTH CARE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

---

EDITORIAL NOTE: Nomenclature changes to chapter V appear at 66 FR 39452, July 31, 2001, and 67 FR 36540, May 24, 2002.

## SUBCHAPTER A—GENERAL PROVISIONS

<i>Part</i>		<i>Page</i>
1000	Introduction; general definitions .....	719

## SUBCHAPTER B—OIG AUTHORITIES

1001	Program integrity—Medicare and State health care programs .....	722
1002	Program integrity—State-initiated exclusions from Medicaid .....	771
1003	Civil money penalties, assessments and exclusions	773
1004	Imposition of sanctions on health care practitioners and providers of health care services by a Quality Improvement Organization .....	790
1005	Appeals of exclusions, civil money penalties and assessments .....	798
1006	Investigational inquiries .....	807
1007	State Medicaid fraud control units .....	808
1008	Advisory opinions by the OIG .....	813